NEWBORN HISTORY

Patient's Name____ DOB____________________

(If patient is greater than two years of age, skip to side 2)

Please fill in or check off each item.
This information will help us provide your child with quality medical care.

NEWBORN HISTORY (Full-term = 40 weeks)

How many weeks?__________

Birthweight________________

Hepatitis shot at hospital? ☐ yes ☐ no

Which pregnancy was this for mom?__________

How many living children?__________

Mom's age at babies birth?__________

BABY'S DELIVERY

Vaginal ____________

C-Section ____________

Induced ____________

Spontaneous ____________

	Yes	No	Not Sure
Did the baby have any problems at birth?	☐	☐	☐
Time in intensive care nursery?	☐	☐	☐
Jaundice, high bilirubin?	☐	☐	☐
Need bili-lights?	☐	☐	☐
Infections?	☐	☐	☐
Medications?	☐	☐	☐
Were there any complications with the pregnancy, labor, delivery or birth?	☐	☐	☐

Please fill in if you had the following during your pregnancy with this child:

	1ST 3 MONTHS	2ND 3 MONTHS	3RD 3 MONTHS
INFECTIONS — Cold, Flu — Chlamydia, Gonorrhea, etc. — Bladder Infections			
MEDICATIONS (Other than vitamins)			
ACCIDENTS OR INJURIES — Did anyone hurt you?			
SMOKING — How many packs/day			
ALCOHOL (Includes beer, wine, other) — Include type of alcohol — How often you drank — Amounts you drank — Include amounts during time you did not know you were pregnant			
DRUGS — Include type — How often			

Name: ______________________________ DOB: ______________

FAMILY HISTORY

Check off if anyone of the following has any of these conditions:

	No	Father	Mother	Paternal Grandpa	Paternal Grandma	Maternal Grandpa	Maternal Grandma	Patient Siblings
List **on this line** if the relative is alive (A) or deceased (D)								
High Blood Pressure								
Allergies, Hay Fever								
Diabetes								
Heart Disease (heart attack, strokes) please specify								
High Cholesterol								
Tuberculosis								
Mental Disorder, Depression, Schizophrenia (please specify)								
Asthma								
Anemia								
Arthritis/Joint disorder								
Bleeding Disorders								
Cancer (please list type for each person)								
Hearing loss								
Skin Problems								
Kidney Disease								
Thyroid Problems								
Stomach/Bowel Problems								
Vision Problems (please specify)								
Reactions to Anesthesia								
Alcohol and/or Drug Use								
Smoking								

Is the child adopted? ____ Yes ____ No Do you know the child's family history? ____ Yes ____ No

PREVIOUS HEALTH HISTORY FOR YOUR CHILD (Has your child had any of the following)

Is your child enrolled in special service for: ____Speech ____ Behavior ____ Learning

Trauma/Fractures ______________________________

Chronic or recurrent problems with: ____ Ear infections ____ Asthma/Wheezing ____ Bladder infections

Other ______________________________

Any Hospitalizations? ____ Yes ____ No If yes, age _______, illness ______________________

Any Surgeries? ____ Yes ____ No If yes, age ____, type of surgery ______________________

Any Allergies? ____ Yes ____ No If yes, describe ______________________

LIVING SITUATION

How many people live in your household? ____ # of Adults ____ # of Children

Names and ages of all people in your household ______________________

Parents marital status: ____ Married ____Divorced ____ Separated ____ Single ____Other

If divorced, separated, or single, is the other parent involved? ____ Yes ____ No

Does the child live regularly in another household? ____ Yes ____ No If yes, describe ______________